Report

of the

Examination of

Humana Wisconsin Health Organization Insurance Corporation

Milwaukee, Wisconsin

As of December 31, 2001

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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November 12, 2002

Honorable Connie L. O'Connell
Commissioner of Insurance
Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

HUMANA WISCONSIN HEALTH ORGANIZATION INSURANCE CORPORATION
Milwaukee, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Humana Wisconsin Health Organization Insurance Corporation (the HMO) was conducted in 1997 as of December 31, 1996. The current examination covered the intervening period ending December 31, 2001, and included a review of such 2002 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the HMO
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the HMO's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the HMO to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comments on the remaining areas of the HMO's operations is contained in the examination work papers.

The HMO is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

The Humana Wisconsin Health Organization Insurance Corporation (Humana WHO), is a for-profit mixed model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "a health care plan offered by an organization established under chs. 185, 611, 613, or 614, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the mixed model, the HMO provides care through contracts with clinics and otherwise independent physicians operating out of their separate offices. HMOs compete with traditional fee-for-service and preferred provider plan health insurance delivery systems.

The HMO was incorporated on June 4, 1985, under the provisions of ch. 611, Wis. Stat. It commenced business under its former name, Wisconsin Health Organization Insurance Corporation (Humana WHO) in September of 1985. Humana WHO is a wholly owned subsidiary of CareNetwork, Inc., a Wisconsin corporation which is a wholly owned subsidiary of Humana Inc. Humana WHO became an affiliate in the insurance holding company system on December 20, 1994, when CareNetwork, Inc., was purchased and merged into HWS, Inc., a wholly owned subsidiary of Humana Inc. CareNetwork, Inc., was the survivor of the merger. The name change to Humana Wisconsin Health Organization Insurance Corporation (Humana WHO) was effective June 1, 1995.

The HMO contracts with Independent Provider Associations (IPAs) and clinics for the provision of physician services, including specialty services. Under these contracts, the IPAs and clinics are reimbursed on a fee schedule or discounted fee-for-service basis; with the exception of St. Joseph's Physician Association, Aurora Behavior Health System, Chirotech America Inc., Eye Care of Wisconsin Inc., Home Care Medical, Novacare, Kenosha Physicians Network, Preferred One, Waukesha/Elmbrook Health Care, and Wisconsin Allied Physician Association. These providers are reimbursed on a capitated per member/per month (pmpm) basis. The point of service business with St. Joseph's Physician Association is reimbursed on a discounted fee-for-service basis.

Certain IPA and clinic arrangements have provisions for incentive payments and risk sharing. The incentive payments are based on specific utilization targets, either hospital days per thousand, or a specified loss ratio/projected pmpm cost. Providers that experience utilization or cost that is lower than expected are entitled to a percentage of the imputed savings. Under risk-sharing arrangements, the HMO is at risk for certain claims in excess of a specified amount per-member per-year. The stop-loss level for the one stop-loss agreement with St. Joseph's Physician Association is $10,000.

The initial terms of the IPA and clinic provider contracts vary from one to three years. Thereafter, the contracts automatically renew for additional one-year terms. The agreements may be terminated by either party for breach of material provision with 30 days' prior written notice, following a 30-day period to cure breach. Also, the agreement may be terminated by either party upon 90 to 120 days' written notice prior to the effective date of such termination. The contracts include hold-harmless provisions for the protection of policyholders.

In addition to contracted IPAs and clinics, the HMO contracts with approximately 3,000 individual physicians to provide covered health care services to eligible enrollees. All such direct contracting physicians are reimbursed on a fee schedule or discounted fee-for-services basis. The contracts have one-year terms and may be terminated upon a 30-day written notice. The contracts also contain hold-harmless provisions for the protection of policyholders.

The HMO currently contracts with 22 IPAs and clinics. A listing of the IPAs and clinics the HMO currently has contracts with is included in Addendum I to this report.

The HMO contracts with 28 hospitals to provide inpatient services. Hospitals are reimbursed on either a negotiated per diem, discounted fee-for-service or fee schedule basis. The contracts include hold-harmless provisions for the protection of policyholders. A listing of the hospitals in which the participating physicians have admitting privileges is included to Addendum II of this report. All hospitals have contracts with the HMO.

The HMO's service area is comprised of the following counties: Dodge, Fond du Lac, Green, Jefferson, Kenosha, Manitowoc, Milwaukee, Ozaukee, Racine, Rock, Sheboygan, Walworth, Washington, and Waukesha.

The HMO offers comprehensive health care coverage, subject to riders for deductibles and copayments. The following basic health care coverages are provided:

Physician services
Inpatient services
Outpatient services
Mental health, drug, and alcohol abuse services
Ambulance services
Special dental procedures (oral surgery)
Prosthetic devices and durable medical equipment
Newborn services
Home health care
Preventive health services
Family planning
Hearing exams and hearing aids
Diabetes treatment
Routine eye examinations
Convalescent nursing home service
Prescription drugs--$5.00 copayment
Cardiac rehabilitation, physical, speech, and/or occupational therapy
Physical fitness or health education ($30.00 per year maximum)
Kidney disease treatment
Certain transplants
Chiropractic services

Inpatient mental health and AODA coverage is limited to 30 days and $6,300.00, outpatient mental health and AODA coverage is limited to $1,800 per year, transitional treatment arrangement coverage is limited to $2,700, home health care is limited to 40 visits, and skilled nursing care is limited to 100 days per spell of illness. Emergency room co-pay is waived upon admission into an inpatient facility. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians.

The HMO also has a co-payment plan, in which inpatient services have copayments ranging from $200 to $750 per admission. Office visits have copayments ranging from $5 to $40, and emergency room visits have copayments ranging from $15 to $150. Prescription drug coverage with specified amount of copayments for generic and name brands can be added by rider. In addition, vision and hearing aid coverage can also be attached by rider. Members are required to choose a primary care physician from the listing of participating physicians available.

The HMO offers a point of service product jointly with an affiliate, Humana Insurance Company (HIC). Employer groups are issued two benefit contracts, one from the HMO covering the traditional HMO benefits and an indemnity contract from HIC covering self referred out-of-

network claims. Enrollees electing to receive out of network, non-emergency services are subject to significantly higher copayments and deductibles. The employers are charged one premium per certificate holder for both policies. The premium is split 90% to the HMO and 10% to Humana Insurance Company. The point-of-service (POS) product is administered by the HMO and HIC pays 8% of its share of the premium to the HMO as compensation for the administrative services. HIC also provides stop-loss coverage to the HMO. Losses to the HMO are capped at 90% of its share of the premium. There is an incentive fee payable to the HMO in which a percentage of the indemnity product profit can be distributed to the HMO, based on the indemnity product loss ratio.

The HMO currently markets to groups only using outside, independent agencies and pays a 1% to 6% commission on new and renewal business.

The HMO uses an actuarially determined base as a beginning point in premium determination. This rate is adjusted to reflect the age, sex, occupation, and coverage characteristics for new groups. Experience is reviewed for renewal groups and, based on the review, a recommendation is made regarding adjusting the rate or canceling the group. The base rate is adjusted monthly for inflation and other trending factors.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of four members. All the directors are elected annually to serve a one-year term. Officers are appointed by the board of directors. Members of the HMO's board of directors may also be members of other boards of directors in the holding company group. The board members receive no separate compensation for serving on the board. Currently, the board of directors consists of the following persons:

Name and Residence	Principal Occupation	Term Expires
Michael Benedict McCallister Louisville, KY	President and Chief Operating Officer	2003
Kenneth John Fasola Prospect, KY	Director	Resigned 9/04/2002
Jonathan Thomas Lord, M.D. Louisville, KY	Director	2003
James Elmer Murray Louisville, KY	Director	2003

Officers of the HMO

The officers elected or appointed by the board of directors and serving at the time of this examination are as follows:

Name	Office	Salary
Michael Benedict McCallister	President and Chief Executive Officer	$1,100,119
Brett James McIntyre	Vice President and Treasurer	191,041
Joan Olliges Lenahan	Secretary	205,932
George Grant Bauernfeind	Vice President	228,620
John Michael Bertko	Vice President	437,484
James Harry Bloem	Senior Vice President and Chief Financial Officer	369,136
Stefen Fritz Brueckner	Vice President	178,472
Michael Edward Derdzinski	President - Milwaukee Market	121,758
Thomas Joseph Liston	Senior Vice President	357,852
Heidi Suzanne Margulis	Senior Vice President	290,593
Steven Oscar Moya	Senior Vice President	370,718
Walter Emerson Neely	Vice President, Associate General Counsel and Assistant Secretary	218,416
Kathleen Stephenson Pellegrino	Vice President & Assistant Secretary	275,146
Larry Arlen Rambo	Vice President	340,644
Robert Eugene Shields	Senior Vice President	426,170
Sharon Elaine Ware	Vice President	214,880

The officers listed above may be officers for other companies owned by Humana Inc. The above amounts reflect the total compensation received by each individual for all positions held.

Committees of the Board

The HMO's bylaws allow for the formation of committees by its board of directors. However, there were no board appointed committees serving at the time of this examination.

Management Committees

Listed below are management committees serving at the time of this examination.

QIC/SENIOR LEADERSHIP

Mike Derdzinski, Chair
Titus Muzi, Jr.
Pat Thor, RN, MS, CPHQ
Gary Davis
Scott Austin
Mike Sugden
Albert Tzeel MD
Anne Andryszcyk
Rob Hard
Ed Maszak
Larry Rambo
Dan Haney

HEALTH SERVICES
Albert Tzeel MD, Chair
Dennis Olig RPh
Loren J. Yount, MD
Jack Brown
Jessica Raddemann
Pat Thor, RN, MS, CPHQ
Rita Aschenbrenner
Susan Tatsak
Ginnie Kohanowski
Karen Eggert
Kyla Kack
Coco Rodriguez

H.U.M.A.N.A.
Albert Tzeel, MD, Chair
James E. Casanova, MD
Marsha Davis, MD
Steven Kaplan, MD
Kurt F. Oesterling, MD
Donna Davisoff, MD
Suzana Dudley, MD
Trudy Malone, MD
Loren J. Yount, MD
Dennis Olig, R.Ph.
Pat Thor, RN, MS, CPHQ
Sue Tatsak, RN, MSN, CPHQ
Beverly J. Schmitt, RN, MHSA, CPHQ
Barbara Bessette, RN, BSN, CPHQ
Marybeth Peden, RN, BS, CPHQ
Jessica Raddemann, BS, CHES
James Funk

IPA CLINICAL LEADERS
Albert Tzeel, MD, Chair
Frank McCann, MD
Loren Meyer, MD
Tim McKevett
Thomas Dunigan, MD
Douglas Sleight, MD
Jeff Postles, MD
Raymond Knight, MD
Masood Wasiullah, MD
Kirk Veit, MD
Michael Jaeger, MD
Gerry Larmore, MD
Paul E. Hankwitz, MD
Edwin Fisher, MD
Jim Fonk, MD
Rosanna Ranieri, MD
Tom Roberts, MD
Richard Lofgren, MD
Donald Carr, MD
Dennis Saran, MD
William Burns, MD
James Kuplic, MD
Michael Grajewski, MD
Gregory Blommel, MD
Loren J. Yount, MD
Pat Thor, RN, MS, CPHQ

PEER REVIEW
Albert Tzeel MD, Chair
Loren J Yount MD
James E. Casanova, MD
Steven J. Kaplan, MD
Marsha Davis, MD, R.Ph.
Trudy Malone, MD
Susan Tatsak
Beverly Schmitt
Vicki Spitz
Barb Bessette
Marybeth Peden

DELEGATION
Pat Thor, RN, MS, CPHQ
Ann Andryszcyk
Susan Ault
Rita Aschenbrenner
Eve Biver
Andrea Dassow
Georgiana Robinson
Karen Eggert
Lynn Kerkela
Scott Meyrose
Titus Muzi, Jr.
A.J. Oxley
Marybeth Peden, RN, BS, CPHQ
Regina Phillips

GRIEVANCE
(Rotating Members)
Nancy Melnick, Chair
Ken Johnson, MD
Michael Rietbrock, MD
Albert Tzeel, MD
Mike Derdzinski
Scott Austin
Gary Davis
Pat Thor, RN, MS, CPHQ
Titus Muzi, Jr.
Tim Lee-Wasson
Jan Scott
Marc Wollman
Betty Ritchie
Linda Lee
Michael Gatton
Cathy Reckelberg

SERVICE OPERATIONAL TEAM
Anne Andryszcyk, Chair
Barb Borowski
Bruce Miller
David Fee
Dennis Olig, R.Ph.
Donna Peabody
John Fitzgerald
Pat Thor, RN, MS, CPHQ
Regina Cartwright
Rita Aschenbrenner
Scott Meyrose
Timothy R Smith
Toni Greer-Goodlow
Valinda Vance
Vickie Abreu
Kyla Kack
Nancy Melnick

PEER REVIEW
Michael Gatton
Cathy Reckelberg
Scott Meyrose
Anne Andryszcyk
Victoria Harris
Chris Greene
Barb Bessette
Brian Smith/Valerie Bognar
Kayla Kack

CLINICAL INITIATIVES COMMITTEE
Jim Ehlen
Charlotte Moore
Lisa Weaver
William Fleming
Stephen Schmaltz
Karen Hoskins
Lowell Stephens
David Steele
Karen Feldkamp
Kim King
Stilla McMahon
Ben Miles
Susan Hoffman
Gina Barhoumy
Bob Walt
Marcia Lurin

CREDENTIALING
Albert Tzeel, MD, Chair
Loren J. Yount, MD
Donna D. Davidoff, MD
Sally G. Hunt, MD
Jack H. Deckard, MD
Suzana I. Dudley, MD
Steven J. Kaplan, MD
James H. Zellmer, MD
Lynn Kerkela

The HMO has no employees. Necessary staff is provided through administrative service agreements between the HMO and its affiliates, briefly described below:

1. Two Service Agreements effective February 4, 2002, between Humana Inc., and Humana Wisconsin Health Organization Insurance Corporation (Humana WHO), whereby, Humana WHO is provided with data processing, marketing, insurance, legal, customer billing services, payroll, trade accounts payable, medical claims, commissions and certain other services. Such expenses are charged back to Humana WHO, based on Humana WHO's weighted membership as a percentage of the weighted membership of all companies receiving similar services from Humana Inc.

2. A Service Agreement dated February 4, 2002, between Humana Insurance Company (HIC) and Humana WHO, whereby, Humana WHO is provided marketing, automated customer enrollment, medical underwriting, administrative services and certain other services. Such expenses are charged back to Humana WHO, based upon commercially reasonable rates as agreed to between Humana WHO and HIC.

Humana WHO will be subject to a maximum of 14% of premium, plus $12 per member per month for the services provided in all the service agreements that the company is a party to, currently the two service agreements listed above. The term of the agreements is one year. The agreements shall automatically renew unless notice is given of nonrenewal by either

party at least 90 days prior to the end of the current term. Either party may terminate the agreements at any time upon 90 days' prior written notice to the other party.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

		Amount Required
1.	Minimum capital or permanent surplus	Either: $750,000, if organized on or after July 1, 1989 or $200,000, if organized prior to July 1, 1989
2.	Compulsory surplus	The greater of $750,000 or: If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous 12 months; If the percentage of covered liabilities to total liabilities is at least 90%, 3% of the premium earned in the previous 12 months
3.	Security surplus	The greater of: 140% of compulsory surplus reduced by 1% of compulsory surplus for each $33 million of additional premiums earned in excess of $10 million or 110% of compulsory surplus
4.	Operating funds	Funds sufficient to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;

2. One-third of 1% of premium written in this state in the preceding calendar year.

The HMO has satisfied this requirement for 2001with a deposit of $1,630,000 with the State Treasurer.

Insolvency Protection for Policyholders

Pursuant to s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and

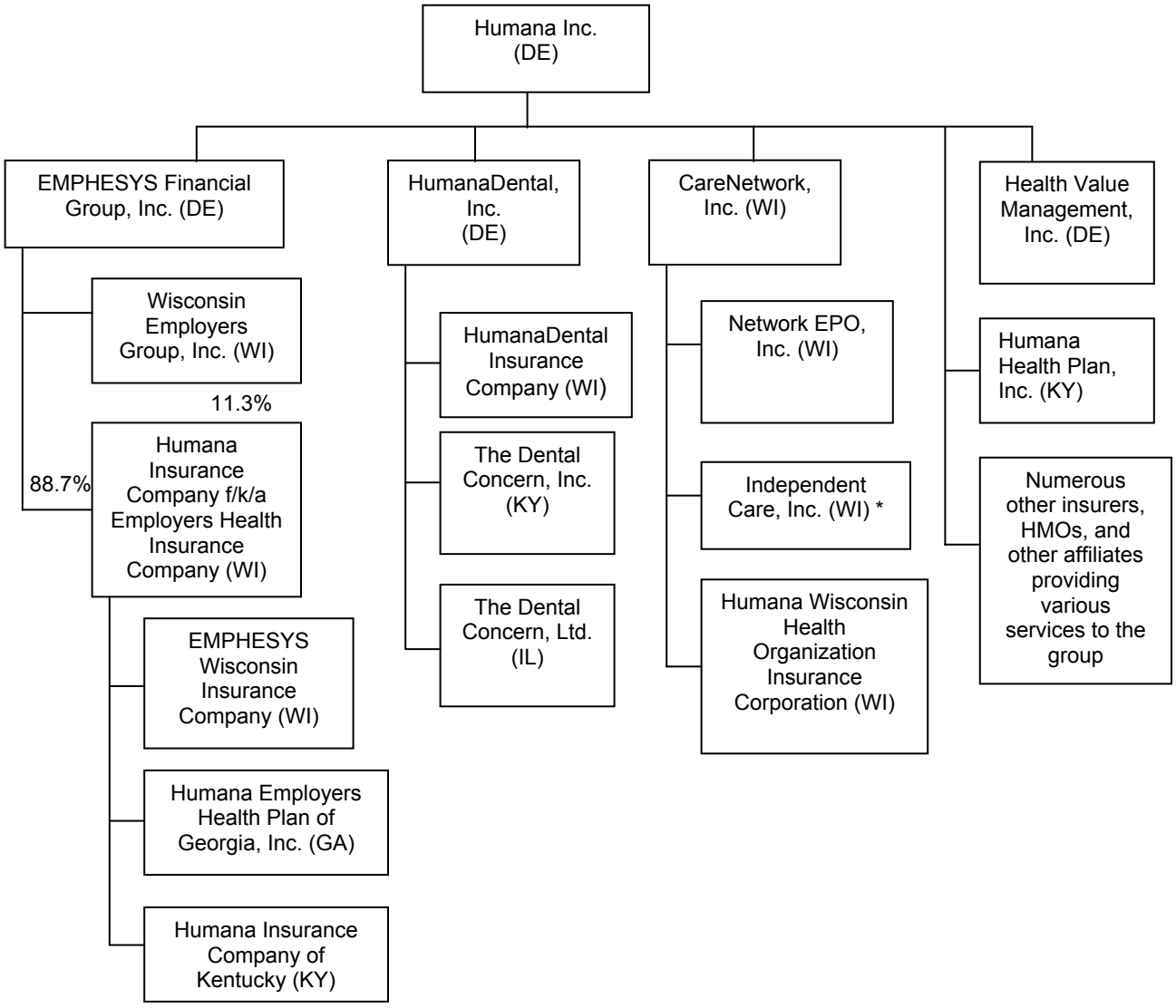
2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The HMO has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report.

IV. AFFILIATED COMPANIES

Humana Wisconsin Health Organization Insurance Company is a member of a holding company system. Its ultimate parent is Humana, Inc. The following organizational chart depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the HMO follows the organizational chart.

Organizational Chart
As of December 31, 2001



* Independent Care, Inc. is 50% owned by CareNetwork, Inc.

Humana Inc.

Humana Inc., is a Delaware corporation offering through its licensed subsidiaries managed health care products which integrate medical management with the delivery of health care services through a network of providers. Such products include HMO, preferred provider arrangements (PPO), point of service (POS), administrative services only (ASO), Medicare, Medicaid, and CHAMPUS. Products are offered primarily through subsidiary health maintenance organizations and preferred provider organizations marketing primarily to employer and commercial groups. The company medical membership as of December 31, 2001, was approximately 6.4 million. As of December 31, 2001, the company's audited financial statement reported assets of $4.4 billion, liabilities of $2.9 billion, and net worth of $1.5 billion. Operations for 2001 produced net income of $117 million.

CareNetwork, Inc.

CareNetwork, Inc., is an inactive intermediate level holding company, which holds ownership of certain subsidiary assets, including Humana WHO, but does not engage in direct business activity. As of December 31, 2001, the company's unaudited financial statement reported assets of $19,229,130, liabilities of ($36,157), and net worth of $19,265,288. The company is an inactive holding company and as such they do not have any income to report.

EMPHESYS Wisconsin Insurance Company

EMPHESYS Wisconsin Insurance Company (EWIC) is a licensed HMO in the state of Wisconsin. As of December 31, 2001, the company's audited financial statement reported assets of $29,581,460, liabilities of $14,258,649, and capital and surplus of $15,322,811. Operations for 2001 produced a net loss of ($1,412,449).

Humana Insurance Company f/k/a Employers Health Insurance Company

Humana Insurance Company (HIC) is a wholly owned life, accident, and health insurer subsidiary of EMPHESYS Financial Group, which is a direct, wholly owned subsidiary of Humana Inc. As of December 31, 2001, the company's audited financial statement reported assets of $976,568,133, liabilities of $448,903,613, and capital and surplus of $527,664,520. Operations for 2001 produced net income of $82,552,604.

Humana Health Plan, Inc.

Humana Health Plan, Inc., is a wholly owned HMO subsidiary of Humana Inc. As of December 31, 2001, the company's audited financial statement reported assets of $432,915,096, liabilities of $279,684,347, and capital and surplus of $153,230,749. Operations for 2001 produced net loss of ($15,300,865).

Agreements with Affiliates

The HMO has the following agreements in force with affiliates, in addition to those agreements mentioned previously in the Management and Control section of this examination report:

1. An Administrative Services and Reinsurance Agreement dated September 1, 1995, between Humana WHO and Humana Insurance Company (HIC). Humana WHO provides administrative services to HIC, and HIC reinsures Humana WHO's excess liability. (This agreement will be replaced with a similar agreement that was filed for approval with the Wisconsin Office of the Commissioner of Insurance on February 3, 2003.)

2. A Tax Allocation Agreement effective December 31, 1995, between Humana Inc., and Humana WHO.

3. An Indemnity Agreement dated June 30, 1995, between Humana Inc., and Humana WHO under the indemnity agreement, Humana Inc., the indemnitor, agrees to indemnify Humana WHO from any and all liability, loss, or damage. Humana WHO may suffer as a result of its failure to perform its obligations arising under certificates of coverage issued to its subscribers should the HMO become insolvent or financially incapable of furnishing such health care services. The indemnitor further guarantees continuation of coverage to subscribers for the duration of the contract period for which payment has been made, and continuation of benefits to the HMO's members who are confined on the date of insolvency in an inpatient facility until their discharge.

Cost Allocation Agreement

The company entered into cost allocation agreement with Humana Insurance Company on October 17, 2000, in order to share in the administrative expenses of operating in the shared market of Milwaukee.

V. REINSURANCE AND CORPORATE INSURANCE

The HMO has reinsurance coverage under the contract outlined below:

1. Reinsurer: St Paul Re Fire and Marine Insurance Company.

   Type: Specific Excess of Loss Reinsurance

   Effective date: January 1, 2002

   Retention: $550,000

   Coverage: For members one year of age - 90% of charges in excess of the retention for hospital services during the contract year if services are provided in a “per diem” or approved fixed procedural fee hospital, 70% if the services are performed in any other hospital;

   For members one year of age or over - 90% of charges in excess of the retention for hospital services during the contract year if services are provided in a “’per diem” or approved fixed procedural fee hospital, 50% if the services are performed in any other hospital, and 50% for retransplantation services performed in any hospital

   Hospital charges are limited to $2,000/day

   There is a $1 million per member/per year maximum benefit subject to $2 million per member/per lifetime maximum benefit

   Premium: $0.11 per-member per-month

   Termination: November 30, 2002, or upon 60 days’ notice by reinsurer

The reinsurance policy has an endorsement containing the following insolvency provisions:

1. St Paul Re Fire and Marine Insurance Company will continue plan benefits for members who are confined on the date of the plan insolvency in a hospital until the earlier of 365 days or the date of discharge.

2. St Paul Re Fire and Marine Insurance Company will continue plan benefits for members who are confined in an acute-care hospital on the date of insolvency until the earlier of 120 days, the date of discharge, or the date covered acute care services cease.

3. St Paul Re Fire and Marine Insurance Company will continue plan benefits for any member insured plan until the end of the contract period for which premiums have been paid to plan by that member or on his behalf, but for not more than 60 days, if such premium is paid prior to the date of plan insolvency.

4. For any members who are Medicaid or Title XVIII Medicare enrollees, 1, 2, and 3 above will apply, subject to the further limit that plan benefits will not extend beyond the date such member is entitled to coverage under other Title XVIII Medicare provisions or any other federal or state program.

Coverage is limited to $5,000,000 in the aggregate, over all other reinsurance agreements that include this type of endorsement, between St. Paul Re Fire and Marine Insurance Company and this plan and any affiliated plans.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the HMO as reported in the December 31, 2001, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the HMO for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Humana Wisconsin Health Organization Insurance Corporation
Assets
As of December 31, 2001

	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$32,678,348	$ 0	$32,678,348
Preferred stocks	870,375	0	870,375
Cash and short-term investments	4,708,304	0	4,708,304
Accident and health premiums due and unpaid	1,480,806	118,348	1,362,458
Investment income due and accrued	544,765	0	544,765
Amounts due from parent, subsidiaries and affiliates	644,286	644,286	0
Furniture and equipment	2,157	2,157	0
Federal and foreign income tax recoverable and interest thereon	6,123,565	3,191,031	2,932,534
Electronic data processing equipment and software	57,446	11,446	46,000
Prepaid commissions	254,019	254,019	0
Deposits	11,479	11,479	0
Total assets	$47,375,550	$4,232,766	$43,142,784

Humana Wisconsin Health Organization Insurance Corporation
Liabilities and Net Worth
As of December 31, 2001

Claims unpaid		$15,961,324
Accrued medical incentive pool and bonus payments		1,602,748
Unpaid claims adjustment expenses		437,847
Aggregate policy reserves		8,295,000
Aggregate claim reserves		255,224
Premiums received in advance		1,232,281
General expenses due or accrued		943,997
Amounts withheld or retained for the account of others		193,614
Other accrued liability		55,916
Third party contingencies		21,035
Total liabilities		28,998,986
Common capital stock	$13,635,500	
Gross paid in and contributed surplus	12,000,000	
Unassigned funds (surplus)	(11,491,702)	
Total capital and surplus		14,143,798
Total liabilities, capital and surplus		$43,142,784

Humana Wisconsin Health Organization Insurance Corporation
Statement of Revenue and Expenses
For the Year 2001

Net premium income		$140,801,859
Aggregate write-ins for other health care related revenues		1,000,000
Total revenues		141,801,859
Medical and Hospital:		
Hospital/medical benefits	$ 90,449,237	
Other professional services	51,522,220	
Emergency room and out-of-area	1,187,365	
Incentive pool and withhold adjustments	75,000	
Total medical and hospital	143,233,822	
Claims adjustment expenses	3,340,672	
General administrative expenses	14,946,692	
Increase in reserves for accident and health contracts	5,685,000	
Total underwriting deductions		167,206,186
Net underwriting gain or (loss)		(25,404,327)
Net investment income earned	2,245,004	
Net realized capital gains or (losses)	447,863	
Net investment gains or (losses)		2,692,867
Aggregate write-ins for other income or expenses		34,867
Net income or (loss) before federal income taxes		(22,676,593)
Federal and foreign income taxes incurred		(7,472,654)
Net income (loss)		$(15,203,939)

Humana Wisconsin Health Organization Insurance Corporation
Capital and Surplus Account
As of December 31, 2001

Capital and surplus prior reporting year		$20,864,839
Net income or (loss)	$(15,203,939)	
Net unrealized capital gains and losses	(109)	
Change in net deferred income tax	3,142,678	
Change in nonadmitted assets	(2,006,604)	
Cumulative effect of changes in accounting principles	2,980,887	
Paid in (surplus adjustments)	2,000,000	
Opt- out prior year adjustment	2,366,046	
Net change in capital and surplus		(6,721,041)
Capital and surplus end of reporting year		$14,143,798

Humana Wisconsin Health Organization Insurance Corporation
Statement of Cash Flows
As of December 31, 2001

Cash from Operations			
Premiums and revenues collected net of reinsurance			$136,706,249
Claims and claims adjustment expenses			148,810,159
General administrative expenses paid			16,046,615
Other underwriting income (expenses)			1,000,000
Cash from underwriting			(27,150,525)
Net investment income			2,393,670
Other income (expenses)			34,867
Federal and foreign income taxes (paid) recovered			7,472,654
Net cash from operations			(17,249,334)
Cash from Investments			
Proceeds from investments sold, matured or repaid:			
Bonds	$36,193,248		
Stocks	1,500,000		
Total investment proceeds		$37,693,248	
Cost of investments acquired (long-term only):			
Bonds		32,115,122	
Net cash from investments			5,578,126
Cash from Financing and Miscellaneous Sources			
Cash provided:			
Surplus notes, capital and surplus paid in	2,000,000		
Other cash provided	5,257,849		
Total		7,257,849	
Cash applied:			
Other applications		8,335,971	
Net cash from financing and miscellaneous sources			(1,078,122)
Net change in cash and short-term investments			(12,749,330)
Cash and short-term investments:			
Beginning of year			17,457,636
End of year			$ 4,708,306

Growth of Humana Wisconsin Health Organization Insurance Corporation

Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Medical Expenses Incurred	Net Income
2001	$43,142,784	$28,998,986	$14,143,798	$140,801,859	$143,233,822	$(15,203,939)
2000	60,939,403	40,074,562	20,864,839	166,058,229	140,783,410	5,394,180
1999	43,052,091	30,129,256	12,922,835	171,691,874	154,192,984	(3,386,696)
1998	44,068,605	30,547,088	13,521,517	153,788,967	136,220,765	(413,719)
1997	45,510,742	34,150,267	11,360,475	169,963,008	149,375,867	(226,189)
1996	46,568,448	33,496,931	13,071,517	159,392,445	144,284,483	1,790,709

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2001	-10.7%	101.0%	12.9%	-41.1%
2000	3.2	84.8	13.0	3.2
1999	-2.0	89.8	14.7	0.5
1998	-0.3	88.6	12.8	-8.9
1997	-0.1	87.9	13.5	-0.9
1996	1.1	90.5	9.8	-2.1

Enrollment and Utilization

Year	Enrollment	Hospital Days/1,000	Average Length of Stay
2001	54,009	329.62	4.0
2000	91,622	328.31	3.1
1999	88,775	336.98	3.7
1998	88,340	262.94	3.2
1997	96,933	250.52	3.3
1996	97,838	242.70	3.2

Per Member Per Month Information

	2001	2000	Percent Change
Premiums:			
Commercial	$187.62	$163.32	14.9%
Expenses:			
Hospital/medical benefits	120.53	90.23	33.6
Other professional services	68.65	47.24	45.3
Emergency room and out-of-area	1.58	0.79	101.1
Other medical and hospital	0.00	0.21	-100.0
Incentive pool and withhold adjustments	0.10	0.00	N/A
Total medical and hospital	190.86	138.46	37.8
Claims adjustment expenses	4.45	0.00	N/A
General administrative expenses	19.92	21.49	-7.3
Increase in reserves for accident and health contracts	7.58	0.00	N/A
Total underwriting deductions	$222.81	$159.95	39.3

During the period under review, assets have decreased by 7.3%, while net worth has increased by 8.2%. The HMO has reported operating losses in four out of the last six years. Humana WHO's surplus was relatively stable between 1996 and 1999, due in part to $8.5 million of paid in surplus from the parent company. In 2000, there was an increase of $7,942,005 that can be mainly attributed to the net income of $5,394,180 for the year and a decrease in non-admitted assets of $2,510,700. The net income is partly attributable to the decrease in administrative cost ratio in 2000 compared to the ratio in 1999. One of the reasons the administrative cost ratio went down was the non-renewal of the Medicare Risk contract on January 1, 2000, resulting in a decline of approximately 3,300 members. Other contributing factors to the net income for the year are a decrease in claims costs, and an increase in premium rates.

The surplus decrease in 2001 was primarily due to a net loss of $15.2 million and was partially offset by a capital contribution of $2 million. Contributing factors to the loss in 2001 are an increase in hospital costs, three large provider groups changing from a capitation arrangement to a discounted fee-for-service and under pricing of several of the company's large accounts, which caused the company to increase its premium deficiency reserve by $5.7 million.

Humana Who's hospital days per thousand for 1999, 2000, and 2001 are higher than average, which when coupled with the increasing average length of stay to four in 2001 and the increase in the premium deficiency reserve contributed to the company's medical loss ratio of 101% for the year. This resulted in a negative profit margin of 10.7%.

Reconciliation of Capital and Surplus per Examination

There were no adjustments or reclassifications to capital and surplus as determined by this examination.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were five specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the HMO are as follows:

1. Claims Payable—It is recommended that the company review its reserving methods so that reserve redundancies do not materially distort operating results.

   Action—Compliance.

2. Medical and Hospital Expenses—It is recommended that Humana WHO adhere to the annual statement instructions in expense classification of medical and hospital and administration components for future regulatory filings.

   Action—Compliance.

3. Provider Agreements—It is recommended that the Company formally request corrective action plans, work with the delegate to correct areas of noncompliance, and conduct follow up site visits, or rescind the delegation agreement.

   Action—Compliance.

4. Contract Provider Claims Accounts—It is recommended that the amount of $850,000, advanced to provider, but under dispute, be classified as non-admitted assets.

   Action—Compliance.

5. Contract Provider Claims Accounts—It is recommended that the liability for cash held in trust for capitated providers be appropriately captioned “Liability for Contract Provider Claim Funds Held in Trust” on future annual statements.

   Action—Compliance.

Summary of Current Examination Results

Financial Reporting

The company's budget consisted of estimates for premium, medical costs, administrative expenses and profit/loss. The detailed assumptions and analyses that were used to develop the budget were not apparent to the examiners in reviewing the budget, the budget was not done on a monthly basis, and it did not make any comparisons between actual and estimated amounts. It is recommended that, in the future, the company prepare a more detailed budget, by month, that includes detailed assumptions and analyses used in developing the budget, along with a comparison between expected and actual results.

Business Plan

The examiners noted changes to the HMO's risk sharing agreements that were not filed with the Office of the Commissioner of Insurance (OCI). According to s. Ins 9.06, Wis. Adm. Code, a health maintenance organization shall file a written report of any proposed substantial change in its business plan. Substantial changes include, among other things, provider agreements, any other change that might affect the financial solvency of the plan, and any changes in the items listed in s. Ins 9.05 (4), which includes, adjusting capitation or fee-for-service rates. Three large provider groups under contract with the HMO switched from a capitation arrangement to a discounted fee-for-service payment plan in 2001. The company was unable to accurately estimate the effect of the change in the risk arrangements on its medical expense trend, resulting in under priced products. It is recommended that the company file proposed changes in its risk sharing agreements at least 30 days prior to the effective date of the proposed change in compliance with s. Ins 9.06, Wis. Adm. Code.

HIRSP Assessment

The Health Insurance Risk Sharing Plan (HIRSP) is a program that provides health insurance for people who would otherwise have difficulty obtaining it. The program is financed partially through assessments of health insurance companies, with the amount of the assessment being based on each company's direct health premium volume.

EMPHESYS Wisconsin Insurance Company (EWIC), which merged with Humana WHO in 2002 (for more on this see section entitled Subsequent Events in a later section of this report), did not correctly file its HIRSP assessment report in 2001. EWIC deducted ceded reinsurance from its premium when reporting premium for the HIRSP assessment. Since the company used net premium instead of direct premium, the amount paid by the company for its HIRSP assessment was understated. It is recommended that the company refile its HIRSP assessments for all years in the examination period by including all required direct premium, including only the allowed deductions in its calculation and use the proper calculation in all future filings.

Claims Payable (Reported and Unreported)

The company is using the incorrect date to age its claims payable. According to the NAIC Annual Statement Instructions - Health claims payable aging begins the date a claim that includes all information necessary to process it is received by the reporting entity for providers that are paid on a fee-for-service basis. The company is currently using the date of service rather than the date the claim was received to age its claims payable in Exhibit 5 of the annual statement. It is recommended that the company correctly fill out Exhibit 5 Claims Payable according to NAIC Annual Statement Instructions - Health.

Premium Deficiency Reserve

A premium deficiency reserve is an additional liability that is recorded when the costs (claim payments, claim adjustment expenses and administration costs) associated with a group of policies (small group, large group, dental, etc) exceeds the premiums to be collected for the remainder of a contract period for those policies. Humana WHO had a premium deficiency reserve in the amount of $8,295,000 at year-end 2001. In the second quarter of 2002, the company increased the premium deficiency reserve to $9,432,000, and at year-end 2002 the reserve increased to $10,883,988. Typically, the premium deficiency reserve is released over the term of the underlying contracts, thereby reducing the reserve over the course of the contract. This, apparently, was not the case for the company.

Humana WHO purports that its fully insured business is dominated by a few jumbo cases. Very large cases are able to negotiate lower premium increases using their size as leverage. In 2001, management concluded that the experience for this book of business was unacceptable. As a result, a multi-year plan was developed to improve profitability while trying to maintain membership. Management states that the results for 2002 are in-line with Humana WHO's multi-year plan and the expectation is for continued progress towards profitability in 2003.

The premium deficiency reserve should be reported as additional policy reserves in the underwriting and investment exhibit part 2D on the annual statement. Humana WHO is incorrectly reporting the premium deficiency reserve as unearned premium reserves. It is recommended that the company properly report its premium deficiency reserves on the underwriting and investment exhibit part 2D according to the NAIC Annual Statement Instructions – Health.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The HMO's calculation as of December 31, 2001, is as follows:

Assets	$ 43,142,784	
Less:		
Special deposit	(1,629,867)	
Liabilities	(28,998,986)	
Examination adjustments	0	
Total		$12,513,931
Net premium earned	140,851,859	
Compulsory factor	3%	
Compulsory surplus		4,225,556
Compulsory Excess		$ 8,288,375

Subsequent Events

Effective June 30, 2002, EMPHESYS Wisconsin Insurance Company (EWIC) merged with Humana Wisconsin Health Insurance Corporation Insurance Company (Humana WHO). Humana WHO is the surviving entity.

VIII. CONCLUSION

Humana Wisconsin Health Organization Insurance Corporation is a for-profit, mixed model health maintenance organization serving the Milwaukee area and surrounding counties. The HMO is a member of the Humana Inc., managed care holding company group. Effective June 30, 2002, EMPHESYS Wisconsin Insurance Company merged with Humana Wisconsin Health Insurance Corporation Insurance Company. Humana WHO is the surviving entity.

Since the prior examination as of 1996, assets have decreased by 7.3%, while net worth has increased by 8.2%. The HMO has reported operating losses in four out of the last six years. Humana WHO's surplus was relatively stable between 1996 and 1999,due in part to $8.5 mllion of capital contributions, however in 2000, there was an increase of $7.9 million. The net loss in 2001 was due to an increase in hospital costs, three large provider groups changing their reimbursement arrangements from capitation to discounted fee-for-service, and under pricing of the company's large accounts which caused the company to increase its premium deficiency reserve by $5,685,000.

Humana Who's hospital days per thousand for 1999, 2000, and 2001 are higher than average. This, along with a four day average length of hospital stay in 2001, contributed to the company's medical loss ratio of 101% for the year. During the period covered by this examination, enrollment has decreased from 97,838 to 54,009. Most of this decrease occurred in 2001, when the decline in the company's membership was 41.1% due to the sale of its Medicaid business.

The company meets minimum surplus requirements. There were no adjustments or reclassifications as a result of this examination. The company complied with all five prior examination report recommendations. This examination resulted in recommendations regarding proper filing of HIRSP assessments, filing amendments to proposed changes to risk sharing agreements, completing a more detailed budget, and properly filling out Exhibit 5 in the annual statement.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

1. Page 26 - Financial Reporting—It is recommended that, in the future, the company prepare a more detailed budget, by month, that includes detailed assumptions and analyses used in developing the budget, along with a comparison between expected and actual results.

2. Page 26 - Business Plan—It is recommended that the company file proposed changes in its risk sharing agreements at least 30 days prior to the effective date of the proposed change in compliance with s. Ins 9.06, Wis. Adm. Code.

3. Page 27 - HIRSP Assessment—It is recommended that the company refile its HIRSP assessments for all years in the examination period by including all required direct premium, including only the allowed deductions in its calculation and use the proper calculation in all future filings.

4. Page 27 - Claims Payable (Reported and Unreported)—It is recommended that the company correctly fill out Exhibit 5 Claims Payable according to NAIC Annual Statement Instructions - Health.

5. Page 28 Premium Deficiency Reserves—It is recommended that the company properly report its premium deficiency reserves on the underwriting and investment exhibit part 2D according to the NAIC Annual Statement Instructions – Health.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance, State of Wisconsin, participated in the examination:

Name	Title
Sonja M Dedrick	Insurance Financial Examiner
Jean M Suchomel	Insurance Financial Examiner
Mark R Knievel	Insurance Financial Examiner

Respectfully submitted,

Kerri L. Miller
Examiner-in-Charge

XI. ADDENDUM I - IPAS AND CLINICS

All Saints Medical Group
Beloit PHO
Children's Medical Group.
Columbia/St Mary's Physicians Network
Covenant Medical Group
Direct Contract Physicians
Falls Medical Group
Fond du Lac Medical Group
Fort Atkinson Medical Group
Holy Family Medical Group
Kenosha Health Services
Kenosha Physicians Network
Lakeshore Clinic
Medical Associates of Menomonee Falls
Medical College of Wisconsin
Milwaukee Medical Clinic
Physicians Health Network of Sheboygan
St. Joseph's Physicians Association
Wisconsin Allied Physicians Association
Watertown PHO
Waukesha/Elmbrook Health Care
West Bend Clinic

XII. ADDENDUM II - HOSPITALS

Beloit Physician Hospital Organization
Children's Hospital of Wisconsin
Columbia Center
Columbia Hospital
Community Memorial Hospital of Menomonee Falls
Elmbrook Memorial Hospital
Fort Atkinson Memorial
Froedtert Memorial Lutheran Hospital
Holy Family Medical Center
Kenosha Hospital and Medical Center
Memorial Hospital of Oconomowoc
Orthopedic Hospital of Wisconsin
Sacred Heart Rehabilitation Hospital
St. Agnes Hospital of Fond du Lac, Wisconsin, Inc.
St. Catherine's Hospital
St. Francis Hospital
St. Joseph's Community Hospital of West Bend, WI
St. Joseph's Hospital
St. Joseph's Hospital - Bluemound
St. Luke's Hospital-Racine
St. Mary's Hospital
St. Mary's Medical Center
St. Mary's Hospital-Ozaukee-
St. Michael's Hospital
St. Nicholas Hospital, Inc.
Watertown Memorial
Waukesha Memorial Hospital
Waupun Memorial Hospital